

***United States Court of Appeals
for the Second Circuit***



EXHIBITS

74-1213

ORIGINAL

independent of service

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

-----x

UNITED STATES OF AMERICA, :
Appellee, :
-against- :
JUAN DANIEL GONZALEZ, JR., : Docket No. 74-1213
Appellant. :
-----x

APPELLANT'S EXHIBITS FOLDER



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Attorney for Appellant
351 Broadway
New York, New York 10013
[212] 431-4600

CONTENTS

The within exhibits are documents from appellant's Selective Service file and were all received in evidence at the trial. They all were prepared at the Armed Forces Examination and Entrance Station (AFEES) at the time of appellant's March 18-19, 1969 pre-induction examination.

They are numbered in their lower right-hand corners, with the same numbers by which they were designated in the trial transcript:

Document #24. Processing Sheet (AFEES) 3/18/69-3/19/69
- "Administrative Reject"
- pending criminal cases
- awaiting trial 4/29/69

Document #25. Record of Induction (DD Form 47) - 3/18/69
- two pending cases
- now in custody of court
- no waiver attached

Document #26. Medical Consultation Sheet (psychiatrist) 3/19/69

Document #27. Report of Medical Exam - 3/18/69
"see consultation sheet"

PROCESSING SHEET AFCS

NAME AND ADDRESS

DATE MAR 18 1969

TAG NO. 1448

NUMBER	PURPOSE	REMARKS
45	SEROLOGY	
2	DENTAL TESTING	
34	AUDIOGRAM RECORDING OF COLOR OF HAIR & OTHER INFORMATION	
108	MISCELLANEOUS SF 68 (2) EYE TEST (1) COLOR VISION	
36	CRIMINALYSIS	
11	HEIGHT & WEIGHT	
37	X-RAY CLASSIFICATION AND FINGERPRINT REVIEW	
14		
52	PSYCHIATRIC COUNSEL	
14	MEDICAL H/C	
14	FINAL MED PRO	
2	SPOT CHECK	APR 19 1969
127	PUBLIC HEALTH	APR 19 1969
19 Mar 69	608 6th LOCAL UNIVERS	APR 19 1969
11	FILE ROOM	
105	INITIAL RECEIVING PT	
104	(IND) INITIAL RECEIVING PT	

KCD-EQH- (18 OCT 66)

Fig. 11 - Plaintiff awaiting trial 29 apr 69 for
 Crim. trespassing & Dis. Con. Verified per Calcasieu
 attorney David La Belle M. J. C. 1914 d. 19.

(24)

P30 87

144

RECORD OF INDUCTION				Form Approved Budget Bureau No. 22-R002.6		DO NOT DEFACE THIS STAMP		
SECTION I - GENERAL (Local Board Will Prepare From Latest Information Available)						Selective Service System LOCAL BOARD NO. 45 44 Court Street Brooklyn, N.Y. 11201 <small>(Local Board of Origin Stamp)</small>		
1. LAST NAME - FIRST NAME - MIDDLE NAME GONZALEZ JR., JUAN DANIEL SSAN: 104-38-7594				2. SERVICE NUMBER (To be entered by Induction Station)		3. CURRENT ADDRESS 104-35 102 Street, Ozone Park NY		
5. HOME OF RECORD (Number and street or rural route - If none no state - city or post office, county and state) (To be entered by Induction Station)								
4. SELECTIVE SERVICE NUMBER		5. DATE OF BIRTH		6. MARITAL STATUS		7. DEPENDENTS		
50	45	47	771	15	Vct. 47	<input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	8. NO. CHILDREN UNDER 18 None	9. OTHER DEPENDENTS (Exclusive of wife, if married, and children indicated in Item 8) None
10. PRIOR MILITARY SERVICE <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes", Complete Name Below)								
11. ARMED FORCE <input type="checkbox"/> ARMY <input type="checkbox"/> NAVY <input type="checkbox"/> AIR FORCE <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> COAST GUARD		12. COMPONENT <input type="checkbox"/> REGULAR <input type="checkbox"/> US <input type="checkbox"/> RES <input type="checkbox"/> NG		13. SERVICE NUMBER		14. DATE OF ENL. IND. APT AND/OR ORDER TO ACTIVE DUTY		
				15. CHARACTER OF DISCHARGE OR SERVICE		16. REASON AND AUTHORITY FOR DISCHARGE OR RELEASE (Check appropriate service regulation)		
17. PRESENT CIVILIAN TRADE OR OCCUPATION (Type of business)				18. LENGTH OF EXPERIENCE <small>YEARS</small> <small>MONTHS</small>				
Educational Trainer								
19. EDUCATION								
GRADE OR YEAR COMPLETED <small>(List through all grades or years successfully completed) (Exclude trade or business schools)</small>		ELEMENTARY AND HIGH SCHOOL		H.S. GRAD.		COLLEGE		
20. PLACE OF BIRTH Ponce, P.R.		21. U.S. CITIZEN <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		22. DATE OF ENTRY INTO U.S. FOR <input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY RESIDENCE		23. IF NOT A U.S. CITIZEN C. ALIEN REGISTRATION RECEIPT CARD NUMBER		
						D. FOREIGN COUNTRY OF WHICH CITIZEN		
24. IF NATURALIZED CITIZEN, GIVE DATE, PLACE, COURT OF JURISDICTION AND NATURALIZATION NUMBER								
25. CONVICTED OR ADJUDICATED OF CRIME OTHER THAN MINOR TRAFFIC VIOLATION (If "Yes", specify crime, date, location of court and sentence) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Criminal trespass, Disorderly Conduct/Pending/ New York Criminal Court								
26. NOW IN CUSTODY OF LAW <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <small>IF ANSWER IS "YES", IS NECESSARY RELEASE OR WAIVER ATTACHED?</small> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
27. CONSCIENTIOUS OBJECTOR <input type="checkbox"/> CLASS MA-HO <input type="checkbox"/> CLS. HO								
28. PREVIOUSLY EXAMINED AND NOT ACCEPTABLE <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes", indicate the following) <input type="checkbox"/> NOT ACCEPTABLE ON PREINDUCTION <input type="checkbox"/> NOT ACCEPTABLE ON INDUCTION <input type="checkbox"/> NOT ACCEPTABLE ON ENLISTMENT								
SECTION II - LOCAL BOARD MEDICAL INTERVIEW								
29. PHYSICAL DEFECTS <small>(To be completed by Local Board)</small>		30. LIST ALL DEFECTS AND DISEASES CLAIMED BY THE REGISTRANT AND ANY DEFECTS OR DISEASES WHICH THE REGISTRANT MAY HAVE, AND WHICH ARE KNOWN TO THE LOCAL BOARD (If no defects, indicate by "None")						
		None						
		31. ARE ANY OF THE DEFECTS OR DISEASES LISTED IN ITEM "29" ABOVE INCLUDED IN LIST OF DEFECTS (Par 1629, 50 Reg)? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
		32. REGISTRANT OR AFFIDAVIT REFERRED TO LOCAL BOARD MEDICAL ADVISOR <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
33. STATEMENT OF LOCAL BOARD MEDICAL ADVISOR (To be Completed If Item 32 Is "Yes") FINDINGS: a. Registrant does not have disqualifying defect(s) claimed b. Registrant has the following disqualifying defect or defects (Specify the principal disqualifying defect first, list all other defects in order of significance, and attach affidavits or statements)								
34. REMARKS								
DATE Mar.10,1969		PLACE 44 Court St., Brooklyn NY		SIGNATURE OF LOCAL BOARD MEDICAL ADVISOR (When Item 32 Is "Yes") G. Atkins, <i>G. Atkins</i>				
				SIGNATURE OF MEMBER OR CLERK OF LOCAL BOARD (When Item 32 Is "No") G. Atkins, <i>G. Atkins</i>				

550

(17)

CLINICAL RECORD		CONSULTATION SHEET	
REQUEST			
TO:	FROM: (Requesting ward, unit, or activity)	DATE OF REQUEST	
N-P	AFFES, FT. HAMILTON	18 Mar 69	
REASON FOR REQUEST (Complaints and findings)			

Classie he ~~is~~ Olaford lead
Columbia student rebellion & was arrested

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE <i>R. W. M.</i>	APPROVED	PLACE OF CONSULTATION <input type="checkbox"/> BEDSIDE <input type="checkbox"/> ON CALL	<input type="checkbox"/> EMERGENCY <input type="checkbox"/> ROUTINE
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CONSULTATION REPORT

This 21^y. old inductee is a member of the SDS and as an active leader in the rebellion he was expelled from Columbia U. He was arrested from twice - criminal trespassing, disorderly conduct - but charges were dropped. He is a typical revolutionary, believing firmly in the Chinese and Cuban revolution and its aims. He is an angry man, but a spite of intensive examination I am unable to detect any psychopathology. I can not pass judgment on political views, as a psychiatrist who finds no psychopathology I have to consider him acceptable.

Because of his beliefs he will present a disciplinary problem.

M. T.

(Continued on reverse side)

SIGNATURE AND TITLE <i>Richard Resnick</i>	DATE <i>3-19-69</i>	IDENTIFICATION NO.	ORGANIZATION
PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; hospital or medical facility)		REGISTER NO. <i>144</i>	WARD NO.

Gonzalez, Juan Daniel

CONSULTATION SHEET
Standard Form 513
513-104

(26)

REPORT OF MEDICAL EXAMINATION

ED-100-61

1. LAST NAME - FIRST NAME - MIDDLE NAME GONZALEZ, JUAN DANIEL			2. GRADE AND COMPONENT OR POSITION Civilian	3. IDENTIFICATION NO. 144
4. HOME ADDRESS (Number, Street or R.F.C.D., City or Town, State and Zip)			5. PURPOSE OF EXAMINATION PRE INDUCT	6. DATE OF EXAMINATION 18MAR69 144
7. SEX MALE	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE MILITARY CIVILIAN	10. AGENCY	11. ORGANIZATION UNIT
12. DATE OF BIRTH 16OCT47	13. PLACE OF BIRTH PONCE PR	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN Mrs Flavinae Gonzalez - Mother SALME 214		
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS AFFEES FT HAMILTON, BROOKLYN NY			16. OTHER INFORMATION 50-045-47-0771 / NONE	TIME IN THIS CAPACITY (Total) LAST SIX MONTHS
17. RATING OR SPECIALTY				

CLINICAL EVALUATION	
NOR- MAL	(Check each item in appropriate col- umn; enter "NE" if not evaluated.)
✓	ABNOR- MAL
✓	18. HEAD, FACE, NECK AND SCALP
✓	19. NOSE
✓	20. SINUSES
✓	21. MOUTH AND THROAT
✓	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)
✓	23. DRUMS (Perforation)
✓	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 61)
✓	25. OPHTHALMOSCOPIC
✓	26. PUPILS (Equality and reaction)
✓	27. OCULAR MOTILITY (Associated parallel move- ments, nystagmus)
✓	28. LUNGS AND CHEST (Include breasts)
✓	29. HEART (Thrum, size, rhythm, sounds)
✓	30. VASCULAR SYSTEM (Varicosities, etc.)
✓	31. ABDOMEN AND VISCERA (Include hernia)
✓	32. ANUS AND RECTUM (Hemorrhoids, Anal canal) (Prostate, if indicated)
✓	33. ENDOCRINE SYSTEM
✓	34. G-U SYSTEM
✓	35. UPPER EXTREMITIES (Strength, range of motion)
✓	36. FEET
✓	37. LOWER EXTREMITIES (Strength, range of motion)
✓	38. SPINE, OTHER MUSCULOSKELETAL
✓	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS
✓	40. SKIN, LYMPHATICS
✓	41. NEUROLOGIC (Equilibrium tests under item 72)
✓	42. PSYCHIATRIC (Specify any personality deviation)
✓	43. PELVIC (Females only) (Check how done)
<input type="checkbox"/> VAGINAL <input type="checkbox"/> RECTAL	

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

SEE CONSULTATION SHEET

4/1/69 RD JP

(Continue in item 73)

14. DENTAL (Place appropriate symbols above or below number of upper and lower teeth, respectively.)

R—Restorable teeth
I—Nonrestorable teeth

X—Missing teeth
XXX—Replaced by dentures

(6 X 8)—Fixed bridge, brackets to
include abutments

REMARKS AND ADDITIONAL DENTAL
DEFECTS AND DISEASES

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
G	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	E
H																	F
T																	T

LABORATORY FINDINGS

45. URINALYSIS: <input checked="" type="checkbox"/> SPECIFIC GRAVITY	46. CHEST X-RAY (Place, date, film number and result) 177 MAR 18 1969	
B. ALBUMIN	D. MICROSCOPIC	
C. SUGAR		
47. SEROLOGY (Sputum test, if any, and result) 4. P.L.D. MEGA 18 MAR 1969	48. EKG	49. BLOOD TYPE AND RH FACTOR
50. OTHER TESTS PT. HAMILTON		

27

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT 70	52. WEIGHT 123	53. COLOR HAIR BROWN	54. COLOR EYES BROWN	55. BUILD: (Check one) X	SLENDER	MEDIUM	HEAVY	OBESE	56. TEMPERATURE		
57. BLOOD PRESSURE (Arm at heart level)					58.	PULSE (Arm at heart level)					
A. SITTING	SYS. DIAS.	B. RECUM. BENT	SYS. DIAS.	C. STANDING (3 MIN.)	SYS. DIAS.	A. SITTING 111	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.	
59. DISTANT VISION					60. REFRACTION	61. NEAR VISION					
RIGHT 20/ 30	CORR. TO 20/ 20		BY -0.75	S.	CX	CORR. TO		BY			
LEFT 20/ 30	CORR. TO 20/ 20		BY -0.75	S.	CX	CORR. TO		BY			
62. HETEROPHORIA (Specify distance) ES* EX* my R.H.					L.H.	PRISM DIV.	PRISM CONV.	PC	PD		
63. ACCOMMODATION RIGHT LEFT					64. COLOR VISION (Test used and result) PIP 14/14			65. DEPTH PERCEPTION (Test used and score)		UNCORRECTED	
66. FIELD OF VISION					67. NIGHT VISION (Test used and score)			68. RED LENS TEST		CORRECTED	
70. HEARING					71. AUDIOMETER					69. INTRAOCCULAR TENSION	
RIGHT WV	/15 SV	/15	RIGHT	250 500 1000 2000 3000 6000 6000	500 1000 2000 2500 4000 6000 6000	1000 1000 1000 1000 1000 1000 1000	1000 1000 1000 1000 1000 1000 1000	1000 1000 1000 1000 1000 1000 1000	1000 1000 1000 1000 1000 1000 1000	72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)	
LEFT WV	/15 SV	/15	LEFT	113	13	13	13	13	13	13	

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

Last Score

Score 70 Per 60%
Dx

(NP)

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

Normal His NP

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

76. A. PHYSICAL PROFILE

P	U	L	H	E	S
1	1	1	1	1	1

B. PHYSICAL CATEGORY

B	C	E
1	1	1

77. EXAMINEE (C/N/R)

INDUCTEE

INDUCTEE

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

79. TYPED OR PRINTED NAME OF PHYSICIAN

JACOB KATZ, M.D.

SIGNATURE

(JAK)

80. TYPED OR PRINTED NAME OF PHYSICIAN

SIGNATURE

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)

SIGNATURE

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY

Martin L. Goldman C.R.

SIGNATURE

NUMBER OF ATTACHED SHEETS

REPORT OF MEDICAL HISTORY

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

89-105-01

1. LAST NAME - FIRST NAME - MIDDLE NAME

GONZALEZ JUAN DANIEL

4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)

104 35 102 ST
 NYC QUEENS NY

7. SEX

MALE

8. RACE

Cau

9. TOTAL YEARS GOVERNMENT SERVICE

MILITARY 0 CIVILIAN 0

12. DATE OF BIRTH

15 OCT 47

13. PLACE OF BIRTH

PONCE PR

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS

AFFES FT. HAMILTON, BROOKLYN NY

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS (Follow by description of past history, if complaint exists)

Fair -

2. GRADE AND COMPONENT OR POSITION

Civilian

3. IDENTIFICATION NO.

144

5. PURPOSE OF EXAMINATION

PRE INDUCT

6. DATE OF EXAMINATION

18 MAR 69 144

10. AGENCY

11. ORGANIZATION UNIT

14. NAME, RELATIONSHIP, AND ADDRESS OF MATE OF EX

Mrs. [unclear] - Mother

Sister 05 44

16. OTHER INFORMATION

50-045-47-0771 / MOVE

18. FAMILY HISTORY

				19. HAS ANY BLOOD RELATION (Parent, brother, sister, other) OR HUSBAND OR WIFE			
RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH	YES	NO	(Check each item)
FATHER			Dad - Cancer	39			RELATION(S)
MOTHER	60	Good					HAD TUBERCULOSIS
SPOUSE							HAD SYPHILIS
BROTHERS	20	Good			✓		HAD DIABETES
AND					✓		HAD CANCER
SISTERS							HAD KIDNEY TROUBLE
CHILDREN							HAD HEART TROUBLE
							HAD STOMACH TROUBLE
							HAD RHEUMATISM (Arthritis)
							HAD ASTHMA, HAY FEVER, HIVES
							HAD EPILEPSY (Fits)
							COMMITTED SUICIDE
							BEEN INSANE

20. HAVE YOU EVER HAD OR HAVE YOU NOW (Place check at left of each item)

YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)
✓		SCARLET FEVER - ERYsipelas	✓		GOITER	✓		TUMOR, GROWTH, CYST, CANCER	✓		TRICK OR LOCKED KNEE
✓		DIPHTHERIA	✓		TUBERCULOSIS	✓		RUPTURE / HERNIA	✓		FOOT TROUBLE
✓		RHEUMATIC FEVER	✓		SOARING SWEATS (Night sweats)	✓		APPENDICITIS	✓		NEURITIS
✓		SWOLLEN OR PAINFUL JOINTS	✓		ASTHMA	✓		PILES OR RECTAL DISEASE	✓		PARALYSIS (Inc. infantile)
✓		MUMPS	✓		SHORTNESS OF BREATH	✓		FREQUENT OR PAINFUL URINATION	✓		EPILEPSY OR FITS
✓		COLOR BLINDNESS	✓		PAIN OR PRESSURE IN CHEST	✓		KIDNEY STONE OR BLOOD IN URINE	✓		CAR, TRAIN, SEA, OR AIR SICKNESS
✓		FREQUENT OR SEVERE HEADACHE	✓		CHRONIC COUGH	✓		SUGAR OR ALBUMIN IN URINE	✓		FREQUENT TROUBLE SLEEPING
✓		DISSINESS OR FAINTING SPELLS	✓		PALPITATION OR POUNDING HEART	✓		BOILS	✓		FREQUENT OR TERRIFYING NIGHTMARES
✓		EYE TROUBLE	✓		HIGH OR LOW BLOOD PRESSURE	✓		VD-SYPHILIS, GONORRHEA, ETC.	✓		DEPRESSION OR EXCESSIVE WORRY
✓		EAR, NOSE OR THROAT TROUBLE	✓		CRAMPS IN YOUR LEGS	✓		RECENT GAIN OR LOSS OF WEIGHT	✓		LOSS OF MEMORY OR AMNESIA
✓		BURNING FEARS	✓		FREQUENT INDIGESTION	✓		ARTHROSIS OR RHEUMATISM	✓		BED WETTING
✓		HEARING LOSS	✓		STOMACH, LIVER OR INTESTINAL TROUBLE	✓		BONE, JOINT, OR OTHER DEFORMITY	✓		NERVOUS TROUBLE OF ANY SORT
✓		CHRONIC OR FREQUENT COLDS	✓		GALL BLADDER TROUBLE OR GALL STONES	✓		LAMENESS	✓		ANY DRUG OR NARCOTIC HABIT
✓		SEVERE TOOTH OR GUM TROUBLE	✓		JAUNDICE	✓		LOSS OF ARM, LEG, FINGER, OR TOE	✓		EXCESSIVE DRINKING HABIT
✓		SINUSITIS	✓		ANY REACTION TO SERUM, DRUG OR MEDICINE	✓		PAINFUL OR TRICK SHOULDER OR ELBOW	✓		HOMOSEXUAL TENDENCIES
✓		HAY FEVER	✓		HISTORY OF BROKEN BONES	✓		RECURRENT BACK PAIN	✓		PERIODS OF UNCONSCIOUSNESS
✓		HISTORY OF HEAD INJURY									
✓		SKIN DISEASES									

21. HAVE YOU EVER (Check each item)

YES	NO	(Check each item)	22. FEMALES ONLY: A. HAVE YOU EVER—	B. COMPLETE THE FOLLOWING:		
✓		WORN GLASSES - CONTACT LENS	ATTEMPTED SUICIDE	BEEN PREGNANT	AGE AT ONSET OF MENSTRUATION	
✓		WORN AN ARTIFICIAL EYE	BEEN A SLEEP WALKER	HAD A VAGINAL DISCHARGE	INTERVAL BETWEEN PERIODS	
✓		WEAR HEARING AIDS	LIVED WITH ANYONE WHO HAD TUBERCULOSIS	BEEN TREATED FOR A FEMALE DISORDER	DURATION OF PERIODS	
✓		STUTTERED OR STammered	COUGHED UP BLOOD	HAD PAINFUL MENSTRUATION	DATE OF LAST PERIOD	
✓		WEAR A BRACE OR BACK SUPPORT	BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION	HAD IRREGULAR MENSTRUATION	QUANTITY	□ NORMAL □ EXCESSIVE □ SCANTY
23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	3	24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS? MONTHS	6 months	25. WHAT IS YOUR USUAL OCCUPATION?	26. ARE YOU (Check one)	RIGHT HANDED □ LEFT HANDED

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED 'YES' MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	<input checked="" type="checkbox"/>	27. HAVE YOU BEEN REFUSED EMPLOYMENT OR BEEN UNABLE TO HOLD A JOB BECAUSE OF: A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.
	<input checked="" type="checkbox"/>	B. INABILITY TO PERFORM CERTAIN MOTIONS
	<input checked="" type="checkbox"/>	C. INABILITY TO ASSUME CERTAIN POSITIONS
	<input checked="" type="checkbox"/>	D. OTHER MEDICAL REASONS (If yes, give reasons)
	<input checked="" type="checkbox"/>	28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?
	<input checked="" type="checkbox"/>	29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (If yes, give details)
	<input checked="" type="checkbox"/>	30. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (If yes, state reason and give details)
	<input checked="" type="checkbox"/>	31. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE, ANY OPERATIONS? (If yes, describe and give age at which occurred)
	<input checked="" type="checkbox"/>	32. HAVE YOU EVER BEEN A PATIENT (Committed or voluntary) IN A MENTAL HOSPITAL OR SANATORIUM? (If yes, specify when, where, why, and name of doctor, and complete address of hospital or clinic)
	<input checked="" type="checkbox"/>	33. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (If yes, specify when, where, and give details)
	<input checked="" type="checkbox"/>	34. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS? (If yes, give complete address of doctor, hospital, clinic, and details)
	<input checked="" type="checkbox"/>	35. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR C冷S? (If yes, which illnesses)
	<input checked="" type="checkbox"/>	36. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (If yes, give date and reason for rejection)
	<input checked="" type="checkbox"/>	37. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability)
	<input checked="" type="checkbox"/>	38. HAVE YOU EVER RECEIVED, IS THERE PENDING, OR HAVE YOU APPLIED FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? (If yes, specify what kind, granted by whom, and what amount, when, why)

WARNING: A FALSE OR DISHONEST ANSWER TO ANY OF THE QUESTIONS ON THIS FORM MAY BE PUNISHED BY FINE OR IMPRISONMENT (18 U.S.C. 1001).

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE

Juan D. Gonzalez

SIGNATURE

Juan D. Gonzalez

39. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician shall comment on all positive answers in items 20 thru 38)

Answer to Ques. 29
College Suspended

College Suspension

Answer to Ques. 30
Answer to Ques. 31

Answer to Ques. 32

VD 1D

Answer to Ques. 33

Katz

TYPED OR PRINTED NAME OF PHYSICIAN

KATZ, M.

DATE

SIGNATURE

NUMBER OF ATTACHED SHEETS

AFFIDAVIT OF SERVICE BY MAIL

STATE OF NEW YORK)
) ss.:
COUNTY OF NEW YORK)

ALLENE F. BOOP , being duly sworn, deposes and says:

That on the 1st day of July, 1974, I served the
within Appellant's Brief, Appellant's Appendix and
Appellant's Exhibit Folder upon David Trager, attorney
for the government in this action, at 225 Cadman Plaza
East, Brooklyn, New York 11201, the address designated,
by depositing a true copy of same, enclosed in a postpaid
properly addressed wrapper, in an official depository
under the exclusive care and custody of the United States
Postal Service within the State of New York.

Alene F. Boop

Sworn to before me this
1st day of July, 1974.

Steven Bernstein

STEVEN BERNSTEIN
NOTARY PUBLIC, STATE OF NEW YORK
No. 314020522
Qualified in New York County
Commission Expires March 30, 1976